HealthShare Exchange

190 N. Independence Mall West | Suite 701 | Philadelphia PA 19106 | 215.391.4905 | www.healthshareexchange.org

HealthShare Exchange (HSX) Patient **Opt-Out Form**

Consumers may use this form to request that their healthcare information NOT be included in the health information exchange (HIE) activities of HealthShare Exchange (HSX), the HIE organization for the Greater Philadelphia and Delaware Valley areas, including southeastern Pennsylvania and southern New Jersey

In HIE, participating healthcare providers exchange patient health and healthcare information, in a secure and confidential way, for purposes of providing care to patients. The health information of individual who submit this Opt-Out Form will NOT be accessible to healthcare providers and other authorized users through the HIE. HSX participants who search for such information will receive a message informing them that the individual has opted out.

This request does not prohibit the individual's healthcare provider from otherwise disclosing the individual's medical information based on other authorizations and applicable law, or by other methods.

Individuals who have opted out can choose to participate in the HIE again at any time by using the Opt-Back-In Form at
https://www.healthshareexchange.org/patient-options-opt-out-back
or by calling (855) 479-7372 (HSX-SEPA) or emailing consent@healthshareexchange.org.

This form supersedes any previously submitted Opt-Back-In Forms to HSX. Therefore, HSX participants who search for information on the individual submitting this form will not receive healthcare information upon request.

Submission of Opt-Out Form

The HSX Opt-Out Form can be completed online at:
https://www.healthshareexchange.org/patient-options-opt-out-back
In addition, HSX will accept either the HSX Opt-Out Form or the PA Patient and Provider Network OPT-Out or OPT-BACK-IN FORM by email to consent@healthshareexchange.org, or by fax submission to 215-422-4333, or through postal mail to:

HealthShare Exchange
American College of Physicians Building
190 N. Independence Mall West, Suite 701
Philadelphia, PA 19106
attention: Consent Management Department

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To opt out, please fill out the information below and submit this form:

Patient Information

First Name* _____
Middle Name _____
Last Name* _____
Maiden Name (If Applicable) _____
Current Address* _____
Current City* _____
Current State* _____
Current Zip Code* _____
Current Country* _____
Primary Phone Number* _____
Secondary Phone Number _____
Current Email Address _____
Date of Birth* (mm/dd/yyyy) _____
Gender* _____
Social Security Number or Last Four Digits _____

* Required Information

Parent or Guardian Information (if applicable)

First Name _____
Last Name _____
Primary Phone Number _____
Current Email Address _____
Relationship _____

Submitter's statement: In completing this Opt-Out Form, I verify that I am the person named above, or I am legally authorized to complete this form for the person named above. The information provided on this form, and the preferences expressed herein, are accurate to the best of my abilities. Date: _____

Notification of Opt Out

Person's submitting this Opt-Out Form, have the right to be notified that their opt out has been completed. Please indicate preferred method of notification:

- ☐ phone
- ☐ letter
- ☐ no notification